

Questionnaire No:

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LIFESTYLE AND HEALTH OF MOTHER

All answers are confidential

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Jade

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Charlie

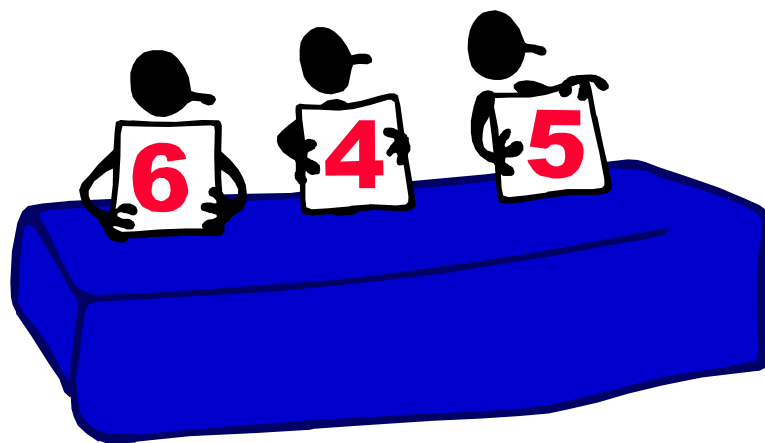
This questionnaire is for the study child's mother or the person taking the role of the mother.

14/05/02

This questionnaire is for the study child's mother or person taking the role of mother.

It will help us to catch up with some current problems you may have, as well as some features of your lifestyle.

Some of the questions we are asking may seem remote from the health of your study child, but the answers will help us to plan for studying the changes that will be occurring in our children as they develop, and how these may be passed down from one generation to the next.



To answer simply tick the box which is most accurate in your opinion.

If you do not want to answer a question or if it does not apply to you, put a line through it. There are no good or bad answers. Just tell us what is true for you.

THANK YOU FOR YOUR HELP

SECTION A: DIZZINESS AND BALANCE

A1. About how many times have you experienced each of the symptoms listed below during the past 12 months:

How often in the past 12 months have you:	More than once a week	More than once a month	4-12 times ↓	1-3 times ↓	Not at all ↓
a) Felt that things are spinning or moving around, lasting less than 2 minutes	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
b) Felt that things are spinning or moving around, lasting up to 20 minutes	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
c) Felt that things are spinning or moving around, lasting 20 minutes to 1 hour	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
d) Felt that things are spinning or moving around, lasting several hours	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
e) Felt that things are spinning or moving around, lasting more than 12 hours	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
f) Felt unsteady, so severe that you actually fell	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
g) Felt nauseous (feeling sick), stomach churning	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
h) Felt light-headed, “swimmy” or giddy lasting less than 2 minutes	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>

A1.		More than once a week	More than once a month	4-12 times ↓	1-3 times ↓	Not at all ↓
How often in the past 12 months have you:						
i)	Felt light-headed, “swimmy” or giddy lasting up to 20 minutes	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
j)	Felt light-headed, “swimmy” or giddy lasting 20 minutes to 1 hour	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
k)	Felt light-headed, “swimmy” or giddy lasting several hours	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
l)	Felt light-headed, “swimmy” or giddy lasting more than 12 hours	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
m)	Vomited	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
n)	Been unable to stand or walk properly without support because you were feeling dizzy	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
o)	Felt unsteady, about to lose balance, lasting less than 2 minutes	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
p)	Felt unsteady, about to lose balance, lasting up to 20 minutes	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
q)	Felt unsteady, about to lose balance, lasting 20 minutes to 1 hour	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
r)	Felt unsteady, about to lose balance, lasting several hours	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
s)	Felt unsteady, about to lose balance, lasting more than 12 hours	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>

A2. How confident are you that you will **not** lose your balance and **not** become unsteady when you do the following nowadays:

	Completely confident ↓	Reasonably confident ↓	Sometimes don't feel confident about it	Not very confident at all	Definitely not confident	Never do this
a) Walk around the house	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>	<div>6</div>
b) Walk up or down stairs	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>	<div>6</div>
c) Bend over and pick up something off the floor	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>	<div>6</div>
d) Reach for a small can/jar off a shelf at eye level	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>	<div>6</div>
e) Stand on your tip toes and reach for something above your head	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>	<div>6</div>
f) Stand on a chair and reach for something	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>	<div>6</div>
g) Sweep the floor	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>	<div>6</div>
h) Walk outside to a parked car	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>	<div>6</div>
i) Get into or out of a car	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>	<div>6</div>
j) Walk across a car park to a supermarket	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>	<div>6</div>
k) Walk up or down a ramp	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>	<div>6</div>

A2.	Completely confident ↓	Reasonably confident ↓	Sometimes don't feel confident about it	Not very confident at all	Definitely not confident	Never do this
l) Walk in a crowded place, where people quickly walk past you	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>	<input type="text" value="6"/>
m) Are bumped into by people as you walk through a shopping centre	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>	<input type="text" value="6"/>
n) Step onto or off an escalator while holding onto the handrail	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>	<input type="text" value="6"/>
o) Step onto or off an escalator while holding onto parcels, which prevent you from holding onto the handrail	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>	<input type="text" value="6"/>
p) Walk outside on icy pavements	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>	<input type="text" value="6"/>

A3. a) Do you have any other difficulty in walking?

Yes No → **If no, go to A4a below**

If yes,

b) Is this due to heart disease or breathing problems?

Yes No → **If no, please describe cause**

Don't know

A4. a) Are you troubled by shortness of breath when hurrying on level ground or walking up a slight hill?

Yes No

b) Do you get short of breath walking with other people of your own age on level ground?

Yes No

A4. c) Do you have to stop for breath when walking at your own pace on level ground?

Yes No

d) Are you short of breath on washing or dressing?

Yes No

A5. Have you ever, without warning:

	Yes	No
a) Suddenly lost the power of an arm?	<input type="text" value="1"/>	<input type="text" value="2"/>
b) Suddenly lost the power of a leg?	<input type="text" value="1"/>	<input type="text" value="2"/>
c) Suddenly been unable to speak properly?	<input type="text" value="1"/>	<input type="text" value="2"/>
d) Suddenly lost consciousness for no apparent reason?	<input type="text" value="1"/>	<input type="text" value="2"/>

Space for comments:

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SECTION B: YOUR HEALTH

B1. Have you ever had any of the following problems:

	Yes, had it recently (in past year)	Yes, in past, not recently	No never
a) hay fever	<div>1</div>	<div>2</div>	<div>3</div>
b) indigestion	<div>1</div>	<div>2</div>	<div>3</div>
c) bulimia	<div>1</div>	<div>2</div>	<div>3</div>
d) asthma	<div>1</div>	<div>2</div>	<div>3</div>
e) eczema	<div>1</div>	<div>2</div>	<div>3</div>
f) epilepsy	<div>1</div>	<div>2</div>	<div>3</div>
g) ME or chronic fatigue syndrome	<div>1</div>	<div>2</div>	<div>3</div>
h) migraine	<div>1</div>	<div>2</div>	<div>3</div>
i) back pain/slipped disc	<div>1</div>	<div>2</div>	<div>3</div>
j) kidney disease*	<div>1</div>	<div>2</div>	<div>3</div>
k) varicose veins	<div>1</div>	<div>2</div>	<div>3</div>
l) haemorrhoids/piles	<div>1</div>	<div>2</div>	<div>3</div>
m) rheumatism	<div>1</div>	<div>2</div>	<div>3</div>
n) arthritis	<div>1</div>	<div>2</div>	<div>3</div>
o) psoriasis	<div>1</div>	<div>2</div>	<div>3</div>
p) stomach ulcer	<div>1</div>	<div>2</div>	<div>3</div>
q) pelvic inflammatory disease (PID)	<div>1</div>	<div>2</div>	<div>3</div>
r) drug addiction	<div>1</div>	<div>2</div>	<div>3</div>
s) alcoholism	<div>1</div>	<div>2</div>	<div>3</div>

	Yes, had it recently (in past year)	Yes, in past, not recently	No never
B1. t) schizophrenia	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>
u) anorexia nervosa	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>
v) severe depression	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>
w) other psychiatric problem*	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>
x) other problem(s)* (please tick & describe)	1 <input type="text"/>	2 <input type="text"/>	

* please tick appropriate box and describe below

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B2. a) Have you ever had diabetes?

Yes 1 No 2 → If **no**, go to B2b on page 10

If **yes**,

i) Have you only had it when you were pregnant?

Yes 1 No 2

ii) How is/was it treated?

insulin injections	<input type="text"/> 1
other drugs	<input type="text"/> 2
diet only	<input type="text"/> 3

iii) How old were you when you first developed it?

<input type="text"/>	<input type="text"/>
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years

B2. b) Have you ever had hypertension (high blood pressure)?

Yes No → If **no**, go to B3 below

If **yes**,

i) Have you had it only when you were pregnant?

Yes No

ii) How old were you when you first developed it? years

iii) Do you have hypertension nowadays?

Yes No

B3. a) Are there any problems for which you have **regular** treatment or medicine nowadays?

Yes No → If **no**, go to B4 below

b) If **yes**, please describe these problems and regular treatment or medicine:

Problem	Treatment or medicine
.....
.....
.....
.....

B4. a) Would you say that you were allergic to anything?

Yes No → If **no**, go to B5 on page 11

B4. b) **If yes, is it to:**

	Yes	No
i) cat	<div>1</div>	<div>2</div>
ii) pollen	<div>1</div>	<div>2</div>
iii) dust	<div>1</div>	<div>2</div>
iv) insect bites or stings	<div>1</div>	<div>2</div>
v) medication (e.g. penicillin)	<div>1</div>	<div>2</div>
vi) something else (Please tick & describe)	<div>1</div>	<div>2</div>

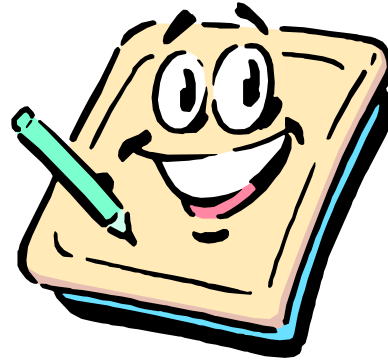
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B5. Have you had any of the following **in the past two years:**

	In the past 2 years:	Yes often	Yes, sometimes	No, not at all
a) attacks of wheezing with whistling on the chest		<div>1</div>	<div>2</div>	<div>3</div>
b) a dry itchy rash		<div>1</div>	<div>2</div>	<div>3</div>
c) a blotchy blistery rash (hives)		<div>1</div>	<div>2</div>	<div>3</div>
d) sneezing attacks		<div>1</div>	<div>2</div>	<div>3</div>
e) runny nose		<div>1</div>	<div>2</div>	<div>3</div>
f) watery eyes		<div>1</div>	<div>2</div>	<div>3</div>
g) attacks of breathlessness		<div>1</div>	<div>2</div>	<div>3</div>
h) cough often during the night		<div>1</div>	<div>2</div>	<div>3</div>
i) cough often when you wake in the morning		<div>1</div>	<div>2</div>	<div>3</div>

Some of these questions may seem familiar to you

Please bear with us— but we do need to ask them again



B6. a) How old were you when your periods first started? years

have not had periods

77

do not remember

99

b) Would you say your periods are regular nowadays?

yes

1

no, not very regular

2

no periods at all

3

→ **If no periods go to B6d below**

↓
If not very regular, go to B7a on page 13

c) If regular, how many days are there from the start of one period to the start of the next one?

days → **now go to B7a on page 13**

d) If you have no periods now, is this because:

you are pregnant

1

you have had a hysterectomy

2

you are menopausal (going through the change)

3

other reason (please tick & describe)

4

don't know

9

.....

B7. a) Have you ever used a contraceptive pill?

Yes No → If **no**, go to B8a below

If **yes**,

b) How old were you when you first took one? years

c) How many years altogether have you taken a contraceptive pill?

under 1 year	<input type="text"/>
1-2 years	<input type="text"/>
3-4 years	<input type="text"/>
5 years or more	<input type="text"/>

d) Are you on the pill now?

Yes No
↓

(i) If **yes**, please give the name of the pill

B8. a) Since your study child's 9th birthday have you been admitted to hospital?

Yes No → If **no**, go to B9 on page 14

If **yes**,

b) how many times?

c) for how many different reasons?

Reason for each hospital stay:

How long did you stay?

d)

nights

e)

nights

f)

nights

g)

nights

h)

nights

↓
Write 00 if you did not stay overnight

B9. a) Have you ever had any pain or discomfort in your chest?

Yes, in past year	<input type="text" value="1"/>	Yes, but not in past year	<input type="text" value="2"/>	No	<input type="text" value="3"/>	→ If <u>no</u> , go to B10 on page 15
If <u>yes</u> ,		go to B9h below				

b) Do/did you get this pain or discomfort when you walk uphill or hurry?

Yes	<input type="text" value="1"/>	No	<input type="text" value="2"/>
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c) Do/did you get the pain or discomfort when you walk at an ordinary pace on the level?

Yes	<input type="text" value="1"/>	No	<input type="text" value="2"/>
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d) When you get/got pain or discomfort in your chest what do you do? (Please tick **one** box only)

stop	<input type="text" value="1"/>	slow down	<input type="text" value="2"/>	continue at the same pace	<input type="text" value="3"/>
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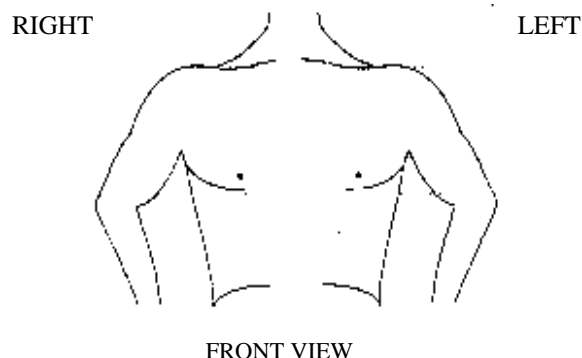
e) Does/did it go away when you stand still?

Yes	<input type="text" value="1"/>	No	<input type="text" value="2"/>	Don't know	<input type="text" value="9"/>
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f) How soon?

10 minutes or less	<input type="text" value="1"/>	More than 10 minutes	<input type="text" value="2"/>	Don't know	<input type="text" value="9"/>
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g) Where do/did you get this pain or discomfort? (Please mark the place(s) with an X on the diagram below) .



h) Have you ever had a severe pain across the front of your chest lasting for half an hour or more?

Yes	<input type="text" value="1"/>	No	<input type="text" value="2"/>	→ If <u>no</u> , go to B10 on page 15
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If **yes**,

B9. i) Did you talk to a doctor about it?

Yes

No

→ If **no**, go to k below

If **yes**,

j) What did they say it was?

.....

.....

k) How many of these attacks have you had?

B10. In the past month, how often have you had any of the following:

In the past month:

**Almost all
the time**

Sometimes

Not at all

a) backache

b) headache or migraine

c) urinary infection

d) nausea

e) vomiting

f) diarrhoea

g) haemorrhoids or piles

h) feeling weepy/tearful

i) feeling irritable

j) feeling exhausted

k) varicose veins

l) passing urine very often

m) problem holding urine
when you jump, sneeze etc.

B10. In the past month:	Almost all the time	Sometimes	Not at all
n) indigestion	1 <input style="border: 1px solid red; width: 40px; height: 25px;" type="text"/>	2 <input style="border: 1px solid red; width: 40px; height: 25px;" type="text"/>	3 <input style="border: 1px solid red; width: 40px; height: 25px;" type="text"/>
o) feeling dizzy/fainting	1 <input style="border: 1px solid red; width: 40px; height: 25px;" type="text"/>	2 <input style="border: 1px solid red; width: 40px; height: 25px;" type="text"/>	3 <input style="border: 1px solid red; width: 40px; height: 25px;" type="text"/>
p) flashing lights/spots before eyes	1 <input style="border: 1px solid red; width: 40px; height: 25px;" type="text"/>	2 <input style="border: 1px solid red; width: 40px; height: 25px;" type="text"/>	3 <input style="border: 1px solid red; width: 40px; height: 25px;" type="text"/>
q) shoulder ache	1 <input style="border: 1px solid red; width: 40px; height: 25px;" type="text"/>	2 <input style="border: 1px solid red; width: 40px; height: 25px;" type="text"/>	3 <input style="border: 1px solid red; width: 40px; height: 25px;" type="text"/>
r) tingling in hands/fingers	1 <input style="border: 1px solid red; width: 40px; height: 25px;" type="text"/>	2 <input style="border: 1px solid red; width: 40px; height: 25px;" type="text"/>	3 <input style="border: 1px solid red; width: 40px; height: 25px;" type="text"/>
s) tingling in feet/toes	1 <input style="border: 1px solid red; width: 40px; height: 25px;" type="text"/>	2 <input style="border: 1px solid red; width: 40px; height: 25px;" type="text"/>	3 <input style="border: 1px solid red; width: 40px; height: 25px;" type="text"/>
t) neck ache	1 <input style="border: 1px solid red; width: 40px; height: 25px;" type="text"/>	2 <input style="border: 1px solid red; width: 40px; height: 25px;" type="text"/>	3 <input style="border: 1px solid red; width: 40px; height: 25px;" type="text"/>
u) feeling depressed	1 <input style="border: 1px solid red; width: 40px; height: 25px;" type="text"/>	2 <input style="border: 1px solid red; width: 40px; height: 25px;" type="text"/>	3 <input style="border: 1px solid red; width: 40px; height: 25px;" type="text"/>
v) other problem (please describe)	1 <input style="border: 1px solid red; width: 40px; height: 25px;" type="text"/>	2 <input style="border: 1px solid red; width: 40px; height: 25px;" type="text"/>	3 <input style="border: 1px solid red; width: 40px; height: 25px;" type="text"/>

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B11. a) Are you currently trying to get pregnant?

<p>no</p> <p>no, but intend to later</p> <p>yes, we are trying</p> <p>I am already pregnant</p>	<div style="border: 1px solid red; width: 40px; height: 25px; margin-bottom: 2px;">1</div> <div style="border: 1px solid red; width: 40px; height: 25px; margin-bottom: 2px;">2</div> <div style="border: 1px solid red; width: 40px; height: 25px; margin-bottom: 2px;">3</div> <div style="border: 1px solid red; width: 40px; height: 25px;">4</div>	<p>→ If <u>yes</u>, (i) for how long have you been trying?</p>	<p>months</p> <div style="border: 1px solid red; width: 60px; height: 25px; margin: 0 auto;"></div> <p>↓</p> <p>now go to B12 on page 18</p>
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If yes, (ii) how long were you trying
before you became pregnant?

months

↓

now go to B12 on page 18

B11. b) What forms of contraception are you and your partner using now? (tick all that you have used in the past 3 months)

	Yes	
i) withdrawal	<input type="checkbox"/>	
ii) the pill	<input type="checkbox"/>	
iii) IUCD/coil	<input type="checkbox"/>	
iv) condom/sheath	<input type="checkbox"/>	
v) calendar/rhythm method	<input type="checkbox"/>	
vi) diaphragm/cap	<input type="checkbox"/>	
vii) spermicide	<input type="checkbox"/>	
viii) I am no longer fertile (have been sterilised, etc.)	<input type="checkbox"/>	
ix) my partner has been sterilised	<input type="checkbox"/>	
x) none	<input type="checkbox"/>	
xi) other (please describe)	<input type="checkbox"/>

Thank you so much for helping us with these delicate questions

A BIT ABOUT SEXUAL MATTERS

We would now like to ask you briefly about a common medical condition that is very important to some people. However, if you are not happy with answering this section, please continue with Section C.

B12. a) Do you ever have pain or discomfort because of a dry vagina?

Not at all	<input type="text" value="1"/>
A little	<input type="text" value="2"/>
Moderate	<input type="text" value="3"/>
A lot	<input type="text" value="4"/>

b) Do you have pain or soreness in the vagina when you have sexual intercourse?

Not at all	<input type="text" value="1"/>
A little	<input type="text" value="2"/>
Moderate	<input type="text" value="3"/>
A lot	<input type="text" value="4"/>

c) How often do you have pain elsewhere after sexual intercourse?

Never	<input type="text" value="1"/>	
Occasionally	<input type="text" value="2"/>	<input type="text"/>
Often	<input type="text" value="3"/>	
Always	<input type="text" value="4"/>	
Don't have sex	<input type="text" value="5"/>	

Please describe:

d) where is pain?

e) how long after sex?

SECTION C: ALL ABOUT YOUR WATERWORKS

C1. a) During the day, how many times do you urinate (pass water or have a wee) on average?

1 - 6 times	<div>1</div>
7 - 8 times	<div>2</div>
9 - 10 times	<div>3</div>
11 – 12 times	<div>4</div>
13 or more times	<div>5</div>

b) During the night, how many times do you have to get up to urinate, on average?

None	<div>1</div>
Once	<div>2</div>
Twice	<div>3</div>
Three times	<div>4</div>
Four times or more	<div>5</div>

c) How often do you have to rush to the toilet to urinate?

Never	<div>1</div>
Occasionally	<div>2</div>
Sometimes	<div>3</div>
More often than not	<div>4</div>
Every time	<div>5</div>

d) Does urine leak before you can get to the toilet?

Never	<div>1</div>
Occasionally	<div>2</div>
Sometimes	<div>3</div>
Most times	<div>4</div>
Every time	<div>5</div>

C1. e) Does urine leak when you are physically active, exert yourself, cough or sneeze?

Never	<div>1</div>
Occasionally	<div>2</div>
Sometimes	<div>3</div>
Most times	<div>4</div>
Every time	<div>5</div>

f) Do you ever leak urine for no obvious reason and without feeling that you want to go?

Never	<div>1</div>
Occasionally	<div>2</div>
Sometimes	<div>3</div>
Most of the time	<div>4</div>
All of the time	<div>5</div>

g) How often is there a delay before you can start to urinate?

Never	<div>1</div>
Occasionally	<div>2</div>
Sometimes	<div>3</div>
Most times	<div>4</div>
Every time	<div>5</div>

h) Do you have to strain to urinate?

Never	<div>1</div>
Occasionally	<div>2</div>
Sometimes	<div>3</div>
Most times	<div>4</div>
Every time	<div>5</div>

C1. i) Do you stop and start more than once while you urinate without meaning to?

Never	<input type="text" value="1"/>
Occasionally	<input type="text" value="2"/>
Sometimes	<input type="text" value="3"/>
Most times	<input type="text" value="4"/>
Every time	<input type="text" value="5"/>

j) How often do you leak urine when you are asleep?

Never	<input type="text" value="1"/>
Occasionally	<input type="text" value="2"/>
Sometimes	<input type="text" value="3"/>
Most of the time	<input type="text" value="4"/>
All of the time	<input type="text" value="5"/>

k) Have you ever blocked up completely so that you could not urinate at all and had to have a catheter to drain the bladder?

Never	<input type="text" value="1"/>
Yes, once	<input type="text" value="2"/>
Yes, twice	<input type="text" value="3"/>
Yes, more than twice	<input type="text" value="4"/>

l) How often have you had a burning feeling when you urinate?

Never	<input type="text" value="1"/>
Occasionally/once	<input type="text" value="2"/>
Sometimes	<input type="text" value="3"/>
Most times	<input type="text" value="4"/>
Always	<input type="text" value="5"/>

C1. m) How often do you feel that your bladder has not emptied properly after you have urinated?

Never	<div>1</div>
Occasionally	<div>2</div>
Sometimes	<div>3</div>
Most of the time	<div>4</div>
All of the time	<div>5</div>

n) If you had to spend the rest of your life with any urinary symptoms that you may have now, how would you feel?

No particular symptoms	<div>1</div>
Perfectly happy	<div>2</div>
Pleased	<div>3</div>
Mostly satisfied	<div>4</div>
Mixed feelings	<div>5</div>
Mostly dissatisfied	<div>6</div>
Very unhappy	<div>7</div>
Desperate	<div>8</div>

SECTION D: ACCIDENTS AND INJURIES

D1. Have you had any accidents of the following types in the last four years (since your study child's 7th birthday)? [If you had more than 1 of the same type of accident, answer for the most serious]

	Yes & stayed in hospital	Yes & saw a doctor	Yes, but did not see a doctor	No, never happened
a) Road traffic accident	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
b) Playing sport or games	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
c) At your place of work	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
d) Inside your home	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
e) Outside your home (e.g. in garden)	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
f) At another building	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
g) During a fight or argument	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
h) You were attacked	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
i) Other type of accident (please tick & describe)	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>

.....

D2. Have you had any of the following injuries in the last four years (since your study child's 7th birthday)?

	Yes & stayed in hospital	Yes & saw a doctor	Yes, but did not see a doctor	No, never happened
You were:				
a) burnt	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
b) scalded	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
c) badly cut	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
d) stabbed	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
e) shot	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
f) nearly drowned	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>

D2.

You had a:		Yes & stayed in hospital	Yes & saw a doctor	Yes, but did not see a doctor	No, never happened
g)	dislocated hip, shoulder, knee, etc.	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
h)	broken arm or hand	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
i)	broken leg or foot	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
j)	sexual assault	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
k)	overdose of pills or medicine	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
l)	overdose of something else (please tick & describe)	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
.....					
m)	concussion	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
n)	other injury (please tick & describe)	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>

.....

If 'no' to all of these, go to E1 on page 26

D3. What physical problems did you have as a result of any of these accidents or injuries? (please tick all that apply)

Results of accident:		Yes & still present	Yes but no longer present	No did not happen
a)	pain	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>
b)	reduction in movement	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>
c)	a facial scar or defect	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>
d)	less able to see or hear	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>
e)	inability to work	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>
f)	other physical result (please tick & describe)	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>

D4. What emotional problems did you have as a result of any of these accidents or injuries?
(please tick all that apply)

Results of accident:	Yes & still present	Yes but no longer present	No did not happen
a) loss of self confidence	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
b) feeling of depression	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
c) very tense	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
d) unable to sleep well	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
e) loss of appetite	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
f) something else (please tick & describe)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

.....

D5. What other consequences of any of these accidents or injuries were there?

Results of accident:	Yes & still present	Yes but no longer present	No did not happen
a) cost money	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
b) lost job	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
c) less earnings	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
d) problems at work	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
e) problems with partner or the family	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
f) problems with friends	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
g) other problem (please tick & describe)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

.....

SECTION E: YOUR FEELINGS

The questions in this section ask you about your feelings and the way you behave. You have answered these questions in other questionnaires, but you might be feeling differently **now**.

Please indicate the way you feel:

	Nowadays	Very often	Often	Not very often	Never
E1.	Do you feel upset for no obvious reason?	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
E2.	Have you felt as though you might faint?	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
E3.	Do you feel uneasy and restless?	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
E4.	Do you sometimes feel panicky?	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
E5.	Do you worry a lot?	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
E6.	Do you feel strung-up inside?	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
E7.	Do you ever have the feeling you are going to pieces?	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
E8.	Do you have bad dreams which upset you when you wake up?	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>

Your feelings in the past week.

E9. I have been able to laugh and see the funny side of things:

As much as I always could	<div>1</div>
Not quite so much now	<div>2</div>
Definitely not so much now	<div>3</div>
Not at all	<div>4</div>

In the past week:

E10. I have looked forward with enjoyment to things:

As much as I ever did	<div>1</div>
Rather less than I used to	<div>2</div>
Definitely less than I used to	<div>3</div>
Hardly at all	<div>4</div>

E11. I have blamed myself unnecessarily when things went wrong:

Yes, most of the time	<div>1</div>
Yes, some of the time	<div>2</div>
Not very often	<div>3</div>
Never	<div>4</div>

E12. I have been anxious or worried for no good reason:

No, not at all	<div>1</div>
Hardly ever	<div>2</div>
Yes, sometimes	<div>3</div>
Yes, often	<div>4</div>

E13. I have felt scared or panicky for no good reason:

Yes, quite a lot	<div>1</div>
Yes, sometimes	<div>2</div>
No, not much	<div>3</div>
No, not at all	<div>4</div>

In the past week:

E14. Things have been getting on top of me:

Yes, most of the time I haven't
been able to cope

Yes, sometimes I haven't been
coping as well as usual

No, most of the time I have
coped quite well

No, I have been coping as well
as ever

E15. I have been so unhappy that I have had difficulty sleeping:

Yes, most of the time

Yes, sometimes

Not very often

No, not at all

E16. I have felt sad or miserable:

Yes, most of the time

Yes, sometimes

Not very often

No, not at all

E17. I have been so unhappy that I have been crying:

Yes, most of the time

Yes, quite often

Only occasionally

Never

In the past week:

E18. The thought of harming myself has occurred to me:

Yes, quite often	<div>1</div>
Sometimes	<div>2</div>
Hardly ever	<div>3</div>
Never	<div>4</div>

E19. On the whole are there more good days than bad?

Yes, more good days	<div>1</div>
About half and half	<div>2</div>
No, more bad days	<div>3</div>

SECTION F: RECENT EVENTS

Listed below are a number of events which may have brought changes in your life. Have any of these occurred since your study child's 9th birthday?

Since the child's 9th birthday:		Yes, when the study child was 9 or 10 ↓	Yes, since the child's 11th birthday ↓	No, did not happen in this period ↓
F1.	Your husband/partner died	<div>1</div>	<div>2</div>	<div>4</div>
F2.	One of your children died	<div>1</div>	<div>2</div>	<div>4</div>
F3.	A friend or relative died	<div>1</div>	<div>2</div>	<div>4</div>
F4.	One of your children was ill	<div>1</div>	<div>2</div>	<div>4</div>
F5.	Your husband or partner was ill	<div>1</div>	<div>2</div>	<div>4</div>
F6.	A friend or relative was ill	<div>1</div>	<div>2</div>	<div>4</div>
F7.	You were admitted to hospital	<div>1</div>	<div>2</div>	<div>4</div>
F8.	You were in trouble with the law	<div>1</div>	<div>2</div>	<div>4</div>
F9.	You were divorced	<div>1</div>	<div>2</div>	<div>4</div>
F10.	You found that your husband/partner didn't want your child	<div>1</div>	<div>2</div>	<div>4</div>
F11.	You were very ill	<div>1</div>	<div>2</div>	<div>4</div>
F12.	Your husband/partner lost his job	<div>1</div>	<div>2</div>	<div>4</div>

		Yes, when the study child was 9 or 10 ↓	Yes, since the child's 11 th birthday ↓	No, did not happen in this period ↓
Since the child's 9 th birthday:				
F13.	Your husband/partner had problems at work	1 <input type="text"/>	2 <input type="text"/>	4 <input type="text"/>
F14.	You had problems at work	1 <input type="text"/>	2 <input type="text"/>	4 <input type="text"/>
F15.	You lost your job	1 <input type="text"/>	2 <input type="text"/>	4 <input type="text"/>
F16.	Your husband/partner went away	1 <input type="text"/>	2 <input type="text"/>	4 <input type="text"/>
F17.	Your husband/partner was in trouble with the law	1 <input type="text"/>	2 <input type="text"/>	4 <input type="text"/>
F18.	You and your husband/ partner separated	1 <input type="text"/>	2 <input type="text"/>	4 <input type="text"/>
F19.	Your income was reduced	1 <input type="text"/>	2 <input type="text"/>	4 <input type="text"/>
F20.	You argued with your husband/partner	1 <input type="text"/>	2 <input type="text"/>	4 <input type="text"/>
F21.	You argued with your family and friends	1 <input type="text"/>	2 <input type="text"/>	4 <input type="text"/>
F22.	You moved house	1 <input type="text"/>	2 <input type="text"/>	4 <input type="text"/>
F23.	Your husband/partner was physically cruel to you	1 <input type="text"/>	2 <input type="text"/>	4 <input type="text"/>
F24.	You became homeless	1 <input type="text"/>	2 <input type="text"/>	4 <input type="text"/>
F25.	You had a major financial problem	1 <input type="text"/>	2 <input type="text"/>	4 <input type="text"/>
F26.	You got married	1 <input type="text"/>	2 <input type="text"/>	4 <input type="text"/>

		Yes, when the study child was 9 or 10 ↓	Yes, since the child's 11 th birthday ↓	No, did not happen in this period ↓
Since the child's 9 th birthday:				
F27.	Your husband/partner was physically cruel to your children	1 <input type="text"/>	2 <input type="text"/>	4 <input type="text"/>
F28.	You were physically cruel to your children	1 <input type="text"/>	2 <input type="text"/>	4 <input type="text"/>
F29.	You attempted suicide	1 <input type="text"/>	2 <input type="text"/>	4 <input type="text"/>
F30.	You were convicted of an offence	1 <input type="text"/>	2 <input type="text"/>	4 <input type="text"/>
F31.	You became pregnant	1 <input type="text"/>	2 <input type="text"/>	4 <input type="text"/>
F32.	You started a new job	1 <input type="text"/>	2 <input type="text"/>	4 <input type="text"/>
F33.	You returned to work	1 <input type="text"/>	2 <input type="text"/>	4 <input type="text"/>
F34.	You had a miscarriage	1 <input type="text"/>	2 <input type="text"/>	4 <input type="text"/>
F35.	You had an abortion	1 <input type="text"/>	2 <input type="text"/>	4 <input type="text"/>
F36.	You took an examination	1 <input type="text"/>	2 <input type="text"/>	4 <input type="text"/>
F37.	Your husband/partner was emotionally cruel to you	1 <input type="text"/>	2 <input type="text"/>	4 <input type="text"/>
F38.	Your husband/partner was emotionally cruel to your children	1 <input type="text"/>	2 <input type="text"/>	4 <input type="text"/>
F39.	You were emotionally cruel to your children	1 <input type="text"/>	2 <input type="text"/>	4 <input type="text"/>

Since the child's 9 th birthday:		Yes, when the study child was 9 or 10 ↓	Yes, since the child's 11 th birthday ↓	No, did not happen in this period
F40.	Your house or car was burgled	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="4"/>
F41.	You found a new partner	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="4"/>
F42.	One of your children started school	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="4"/>
F43.	Your husband/partner started a new job	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="4"/>
F44.	A pet died	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="4"/>
F45.	You had an accident (please tick and describe)	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="4"/>

F46. a) Is there anything else which is not on the list which has concerned you or required additional effort from you to cope since the study child's 9th birthday?

Yes No → Go to F47a on page 34

If **yes**,

please describe for each event:

what happened:		(i) When the study child was 9 or 10	(ii) Since the child's 11 th birthday
b)	<input type="text" value="1"/>	<input type="text" value="1"/>
c)	<input type="text" value="1"/>	<input type="text" value="1"/>
d)	<input type="text" value="1"/>	<input type="text" value="1"/>

F47. a) Has anything else occurred which made you especially happy?

Yes No → **Go to Section G on page 35**

If yes,

please describe for each event:

		(i) When the study child was 9 or 10	(ii) Since the child's 11 th birthday
what happened:			
b)	<input type="text" value="1"/>	<input type="text" value="1"/>
c)	<input type="text" value="1"/>	<input type="text" value="1"/>
d)	<input type="text" value="1"/>	<input type="text" value="1"/>

SECTION G: ACTIVITIES AND LIFESTYLE

G1. On average, over the **past year**, about how many hours sleep do you get:

- a) on work days

--	--

 hours

--	--

 minutes
- b) on weekends (If you normally go out to work at weekends, then answer for your days off)
- | | |
|--|--|
| | |
|--|--|

 hours

--	--

 minutes

G2. a) Have you ever been a smoker?

Yes

1

 No

2

 → **If no, go to G3 on page 36**

If yes,

b) At what age did you start smoking regularly?

--	--

 years

c) Which of the following have you ever smoked regularly?

- | | Yes | |
|---------------|--|---|
| i) cigarettes | <table border="1"><tr><td style="width: 20px; height: 20px; text-align: center;">1</td></tr></table> | 1 |
| 1 | | |
| ii) pipe | <table border="1"><tr><td style="width: 20px; height: 20px; text-align: center;">1</td></tr></table> | 1 |
| 1 | | |
| iii) cigar | <table border="1"><tr><td style="width: 20px; height: 20px; text-align: center;">1</td></tr></table> | 1 |
| 1 | | |
| iv) other | <table border="1"><tr><td style="width: 20px; height: 20px; text-align: center;">1</td></tr></table> | 1 |
| 1 | | |

d) Have you now stopped smoking?

Yes

1

 No

2

 → **If no, go to G2e on page 36**

If yes, how long ago?

--	--

 years

--	--

 months

G2. e) Have you smoked regularly in the last 2 weeks?

No 1 Yes, cigarettes 2 Yes, cigars 3 Yes, pipe 4

Yes, other 5 (please describe)

f) How many times per day have you smoked in the last 2 weeks?

30+ <input type="text"/> 30	25-29 <input type="text"/> 25	20-24 <input type="text"/> 20	15-19 <input type="text"/> 15
10-14 <input type="text"/> 10	5-9 <input type="text"/> 05	1-4 <input type="text"/> 01	0 <input type="text"/> 00

g) What brand of cigarette/tobacco do you smoke?

i) brand

ii) type: filtered 1 unfiltered 2 roll-your-own 3

pipe/cigar 4

G3. a) Does your live-in husband or partner smoke?

Don't have a husband/partner	<input type="text"/> 1	} → If <u>no</u>, or <u>don't have</u> a husband or partner, go to G4 on page 37
No	<input type="text"/> 2	
Yes, cigarettes	<input type="text"/> 3	
Yes, cigars	<input type="text"/> 4	
Yes, pipe	<input type="text"/> 5	
Yes, other (please describe)	<input type="text"/> 6	

If yes,

b) About how many times per day does your husband or partner smoke at the moment?

30+ <input type="text"/> 30	25-29 <input type="text"/> 25	20-24 <input type="text"/> 20	15-19 <input type="text"/> 15
10-14 <input type="text"/> 10	5-9 <input type="text"/> 05	1-4 <input type="text"/> 01	0 <input type="text"/> 00

G3. c) What brand and type of cigarette/tobacco does he usually smoke?

i) brand

ii) type: filtered

1

 unfiltered

2

 roll-your-own

3

 pipe/cigar

4

d) At what age did he

--	--

 years don't know

99

G4. a) Apart from yourself and your husband or partner, are there any other members of your household who smoke?

Yes

1

 No

2

b) **If yes**, how many people?

--	--

G5. How often during the day are you in a room or enclosed place where people are smoking?

	(i) weekdays	(ii) weekends		
all the time	<table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>1</td></tr></table>	1	<table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>1</td></tr></table>	1
1				
1				
more than 5 hours	<table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>2</td></tr></table>	2	<table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>2</td></tr></table>	2
2				
2				
3-5 hours	<table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>3</td></tr></table>	3	<table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>3</td></tr></table>	3
3				
3				
1-2 hours	<table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>4</td></tr></table>	4	<table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>4</td></tr></table>	4
4				
4				
less than 1 hour	<table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>5</td></tr></table>	5	<table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>5</td></tr></table>	5
5				
5				
not at all	<table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>6</td></tr></table>	6	<table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>6</td></tr></table>	6
6				
6				

G6. In the last few months, how often have you used the following whether at home or at work:

	In the last few months	Every day ↓	Most days ↓	About once a week	Less than once a week	Not at all ↓
a)	disinfectant	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
b)	bleach	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
c)	window cleaner	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
d)	chemical carpet cleaner	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
e)	oven/drain cleaner	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
f)	dry cleaning fluid	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
g)	turpentine/white spirit	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
h)	paint stripper	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
i)	household paint or varnish	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
j)	weed killers	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
k)	pesticides/insect killers	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
l)	air fresheners (spray, stick or aerosol)	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>

G6.		Every day ↓	Most days ↓	About once a week	Less than once a week	Not at all ↓
	In the last few months					
m)	other aerosols or sprays including hair spray	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
n)	deodorant or antiperspirant	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
o)	make up	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
p)	glue	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
q)	nail varnish/acetone	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
r)	metal cleaners/ degreasers, polishers	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
s)	petrol	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
t)	moth repellent (moth balls)	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
u)	other chemical (please tick and describe)	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>

.....

G7. a) Do you have a mobile phone (i.e. one that can be used away from home)?

Yes 1 No 2 → **Go to G8 on page 40**

If yes,

G7. b) how often do you use it to make calls?

at least once a day	<input type="text" value="1"/>
4-6 times a week	<input type="text" value="2"/>
1-3 times a week	<input type="text" value="3"/>
less than once a week	<input type="text" value="4"/>

c) how often do people ring you on it?

at least once a day	<input type="text" value="1"/>
4-6 times a week	<input type="text" value="2"/>
1-3 times a week	<input type="text" value="3"/>
less than once a week	<input type="text" value="4"/>

G8. This question concerns travelling, **apart from when going to work:**

a) Which of the following do you use for most or all of the time:

Car	<input type="text" value="1"/>	Public transport	<input type="text" value="2"/>	Neither	<input type="text" value="3"/>
-----	--------------------------------	------------------	--------------------------------	---------	--------------------------------

b) Please indicate the average number of journeys you make **each week** (apart from going to work):

Average distance of most frequent journey

	Average number of journeys each week	Less than $\frac{1}{2}$ mile ↓	$\frac{1}{2}$ - $1\frac{1}{2}$ miles ↓	$1\frac{1}{2}$ - $2\frac{1}{2}$ miles ↓	$2\frac{1}{2}$ - $3\frac{1}{2}$ miles ↓	$3\frac{1}{2}$ - $5\frac{1}{2}$ miles ↓	More than $5\frac{1}{2}$ miles
i) By bicycle	<input type="text"/> <input type="text"/>	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>	<input type="text" value="6"/>
ii) Walking	<input type="text"/> <input type="text"/>	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>	<input type="text" value="6"/>

G9. Please indicate the average hours of TV or Video watched per day over the **past year**:

Average per day over the past year

	None ↓	Less than 1 hour	Between 1 and 2 hours	Between 2 and 3 hours	Between 3 and 4 hours	More than 4 hours
a) On a weekday before 6pm	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
b) On a weekday after 6pm	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
c) On a weekend day before 6pm	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
d) On a weekend day after 6pm	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

G10. How many times do you climb up a flight of stairs (approx 10 steps) each day at home?

Average per day over the past year

	None ↓	1-5 times	6-10 times	11-15 times	16-20 times	More than 20 times
a) On a weekday	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
b) On a weekend day	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

G11. How many hours each week approximately do you spend time doing the following:

Average per week over the past year

	None ↓	Less than 1 hour	Between 1 and 3 hours	Between 3 and 6 hours	Between 6 and 10 hours	Between 10 and 15 hours	More than 15 hours
a) Preparing food, cooking and washing up	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
b) Shopping for food and groceries	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

G11.

Average per week over the past year

	None ↓	Less than 1 hour	Between 1 and 3 hours	Between 3 and 6 hours	Between 6 and 10 hours	Between 10 and 15 hours	More than 15 hours
c) Shopping and browsing in shops for other items (e.g. clothes, toys)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>	<div>6</div>	<div>7</div>
d) Cleaning the house	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>	<div>6</div>	<div>7</div>
e) Doing the washing and ironing	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>	<div>6</div>	<div>7</div>
f) Caring for pre- school children or babies at home (not as paid employment)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>	<div>6</div>	<div>7</div>
g) Caring for handicapped, elderly or disabled people at home (not as paid employment)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>	<div>6</div>	<div>7</div>

SECTION H: ACTIVITY AT WORK

H1. Have you had any jobs or regular voluntary work in the past year?

Yes No → If **no**, go to section I on page 48

H2. What jobs have you held **in the past year**, including voluntary work, and how many months in the year did you do them? Answer for all jobs, whether you stopped one and started another, or whether you were doing them at the same time period.

	(i) Job 1	(ii) Job 2	(iii) Job 3
a) Name of occupation
.....
b) How many hours per week did you usually work? <input type="text"/> <input type="text"/> hours	<input type="text"/> <input type="text"/> hours	<input type="text"/> <input type="text"/> hours	<input type="text"/> <input type="text"/> hours
c) For how many months in the past year did you do this work? <input type="text"/> <input type="text"/> months	<input type="text"/> <input type="text"/> months	<input type="text"/> <input type="text"/> months	<input type="text"/> <input type="text"/> months

H3. Activity during each job:

In the following questions, tick either Yes or No for each activity and write the number of hours **per week** that you spent doing each one:

	(i) Job 1			(ii) Job 2			(iii) Job 3		
	No	Yes	hours	No	Yes	hours	No	Yes	hours
a) Sitting – light work e.g. desk work, or driving a car or truck	<div>1</div>	<div>2</div>	<div></div> <div></div>	<div>1</div>	<div>2</div>	<div></div> <div></div>	<div>1</div>	<div>2</div>	<div></div> <div></div>
b) Sitting – moderate work e.g. driving a mower or forklift truck	<div>1</div>	<div>2</div>	<div></div> <div></div>	<div>1</div>	<div>2</div>	<div></div> <div></div>	<div>1</div>	<div>2</div>	<div></div> <div></div>
c) Standing – light work e.g. lab technician or working at a shop counter	<div>1</div>	<div>2</div>	<div></div> <div></div>	<div>1</div>	<div>2</div>	<div></div> <div></div>	<div>1</div>	<div>2</div>	<div></div> <div></div>
d) Standing – light/moderate work e.g. light welding or stocking shelves	<div>1</div>	<div>2</div>	<div></div> <div></div>	<div>1</div>	<div>2</div>	<div></div> <div></div>	<div>1</div>	<div>2</div>	<div></div> <div></div>
e) Standing–moderate work e.g. fast rate assembly line work or lifting less than 50 lbs every 5 minutes for a few seconds at a time	<div>1</div>	<div>2</div>	<div></div> <div></div>	<div>1</div>	<div>2</div>	<div></div> <div></div>	<div>1</div>	<div>2</div>	<div></div> <div></div>
f) Standing-moderate/heavy work e.g. masonry/painting or lifting more than 50 lbs every 5 minutes for a few seconds at a time	<div>1</div>	<div>2</div>	<div></div> <div></div>	<div>1</div>	<div>2</div>	<div></div> <div></div>	<div>1</div>	<div>2</div>	<div></div> <div></div>
g) Walking at work carrying nothing heavier than a briefcase e.g. moving about a shop	<div>1</div>	<div>2</div>	<div></div> <div></div>	<div>1</div>	<div>2</div>	<div></div> <div></div>	<div>1</div>	<div>2</div>	<div></div> <div></div>

H3.

	(i) Job 1			(ii) Job 2			(iii) Job 3		
	No	Yes	hours	No	Yes	hours	No	Yes	hours
h) Walking – carrying something heavy	<div>1</div>	<div>2</div>	<div></div> <div></div>	<div>1</div>	<div>2</div>	<div></div> <div></div>	<div>1</div>	<div>2</div>	<div></div> <div></div>
i) Moving, pushing heavy objects, weighing over 75 lbs	<div>1</div>	<div>2</div>	<div></div> <div></div>	<div>1</div>	<div>2</div>	<div></div> <div></div>	<div>1</div>	<div>2</div>	<div></div> <div></div>
j) Something else (please tick and describe)	<div>1</div>	<div>2</div>	<div></div> <div></div>	<div>1</div>	<div>2</div>	<div></div> <div></div>	<div>1</div>	<div>2</div>	<div></div> <div></div>
		

H4. How many times **per day on average** have you done the following **at work** over the **past year**:

a) Climbed up a flight of stairs (10 steps):

(i) Job 1	(ii) Job 2	(iii) Job 3
<div></div> <div></div> times	<div></div> <div></div> times	<div></div> <div></div> times

b) Climbed up a ladder:

(i) Job 1	(ii) Job 2	(iii) Job 3
<div></div> <div></div> times	<div></div> <div></div> times	<div></div> <div></div> times

H5. In an average working day, did you:

	Yes	No	Don't know
a) Kneel for more than one hour in total?	<div>1</div>	<div>2</div>	<div>9</div>
b) Squat for more than one hour in total?	<div>1</div>	<div>2</div>	<div>9</div>
c) Get up from kneeling or squatting more than 30 times?	<div>1</div>	<div>2</div>	<div>9</div>

H6. Thinking about **Job 1**:

- a) Roughly how many miles is/was it from home to Job 1? miles
- b) How many times a week do/did you travel from home to Job 1? times
- c) How do/did you normally travel to Job 1?

	Always	Usually	Occasionally	Never or rarely
i) By car	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
ii) By works or public transport	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
iii) By bicycle	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
iv) Walking	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

H7. Thinking about **Job 2** (if appropriate):

- a) Roughly how many miles is/was it from home to Job 2? miles
- b) How many times a week do/did you travel from home to Job 2? times
- c) How do/did you normally travel to Job 2?

	Always	Usually	Occasionally	Never or rarely
i) By car	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
ii) By works or public transport	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
iii) By bicycle	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
iv) Walking	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

H8. Thinking about **Job 3** (if appropriate):

a) Roughly how many miles is/was it from home to Job 3?

--	--

 miles

b) How many times a week do/did you travel from home to Job 3?

--	--

 times

c) How do/did you normally travel to Job 3?

	Always	Usually	Occasionally	Never or rarely				
i) By car	<table border="1" data-bbox="649 607 722 676"><tr><td>1</td></tr></table>	1	<table border="1" data-bbox="842 607 916 676"><tr><td>2</td></tr></table>	2	<table border="1" data-bbox="1042 607 1115 676"><tr><td>3</td></tr></table>	3	<table border="1" data-bbox="1286 607 1359 676"><tr><td>4</td></tr></table>	4
1								
2								
3								
4								
ii) By works or public transport	<table border="1" data-bbox="649 719 722 788"><tr><td>1</td></tr></table>	1	<table border="1" data-bbox="842 719 916 788"><tr><td>2</td></tr></table>	2	<table border="1" data-bbox="1042 719 1115 788"><tr><td>3</td></tr></table>	3	<table border="1" data-bbox="1286 719 1359 788"><tr><td>4</td></tr></table>	4
1								
2								
3								
4								
iii) By bicycle	<table border="1" data-bbox="649 831 722 900"><tr><td>1</td></tr></table>	1	<table border="1" data-bbox="842 831 916 900"><tr><td>2</td></tr></table>	2	<table border="1" data-bbox="1042 831 1115 900"><tr><td>3</td></tr></table>	3	<table border="1" data-bbox="1286 831 1359 900"><tr><td>4</td></tr></table>	4
1								
2								
3								
4								
iv) Walking	<table border="1" data-bbox="649 943 722 1012"><tr><td>1</td></tr></table>	1	<table border="1" data-bbox="842 943 916 1012"><tr><td>2</td></tr></table>	2	<table border="1" data-bbox="1042 943 1115 1012"><tr><td>3</td></tr></table>	3	<table border="1" data-bbox="1286 943 1359 1012"><tr><td>4</td></tr></table>	4
1								
2								
3								
4								

SECTION I: RECREATION ACTIVITIES

- II. Please tell us about the number of times you have done the following activities in the past year, and state the average time spent on each one:

			Number of times you did the activity in the past year					
Average time spent per episode:			Every day	3-6 times a week	Once or twice a week	1-3 times a month	Less than once a month	None ↓
	hours	minutes						
a) Swimming-competitive or laps	<input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> 1	<input type="text"/> 2	<input type="text"/> 3	<input type="text"/> 4	<input type="text"/> 5	<input type="text"/> 6
b) Swimming-leisurely not laps	<input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> 1	<input type="text"/> 2	<input type="text"/> 3	<input type="text"/> 4	<input type="text"/> 5	<input type="text"/> 6
c) Backpacking or mountain climbing	<input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> 1	<input type="text"/> 2	<input type="text"/> 3	<input type="text"/> 4	<input type="text"/> 5	<input type="text"/> 6
d) Walking for pleasure (not as a means of transportation)	<input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> 1	<input type="text"/> 2	<input type="text"/> 3	<input type="text"/> 4	<input type="text"/> 5	<input type="text"/> 6
e) Racing or rough terrain cycling	<input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> 1	<input type="text"/> 2	<input type="text"/> 3	<input type="text"/> 4	<input type="text"/> 5	<input type="text"/> 6
f) Cycling for pleasure (not as a means of transportation)	<input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> 1	<input type="text"/> 2	<input type="text"/> 3	<input type="text"/> 4	<input type="text"/> 5	<input type="text"/> 6
g) Mowing the lawn	<input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> 1	<input type="text"/> 2	<input type="text"/> 3	<input type="text"/> 4	<input type="text"/> 5	<input type="text"/> 6
h) Watering the lawn or garden	<input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> 1	<input type="text"/> 2	<input type="text"/> 3	<input type="text"/> 4	<input type="text"/> 5	<input type="text"/> 6

			Number of time you did the activity in the past year					
11.	Average time spent per episode:		Every day	3-6 times a week	Once or twice a week	1-3 times a month	Less than once a month	None ↓
	hours	minutes						
i) Digging, shovelling or chopping wood	<input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> 1	<input type="text"/> 2	<input type="text"/> 3	<input type="text"/> 4	<input type="text"/> 5	<input type="text"/> 6
j) Weeding, pruning	<input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> 1	<input type="text"/> 2	<input type="text"/> 3	<input type="text"/> 4	<input type="text"/> 5	<input type="text"/> 6
k) DIY e.g. carpentry, home or car maintenance	<input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> 1	<input type="text"/> 2	<input type="text"/> 3	<input type="text"/> 4	<input type="text"/> 5	<input type="text"/> 6
l) High impact aerobics, step aerobics	<input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> 1	<input type="text"/> 2	<input type="text"/> 3	<input type="text"/> 4	<input type="text"/> 5	<input type="text"/> 6
m) Other types of aerobics	<input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> 1	<input type="text"/> 2	<input type="text"/> 3	<input type="text"/> 4	<input type="text"/> 5	<input type="text"/> 6
n) Exercises with weights	<input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> 1	<input type="text"/> 2	<input type="text"/> 3	<input type="text"/> 4	<input type="text"/> 5	<input type="text"/> 6
o) Conditioning exercises e.g. using an exercise bike or rowing machine	<input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> 1	<input type="text"/> 2	<input type="text"/> 3	<input type="text"/> 4	<input type="text"/> 5	<input type="text"/> 6
p) Floor exercises e.g. stretching, bending, keep fit	<input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> 1	<input type="text"/> 2	<input type="text"/> 3	<input type="text"/> 4	<input type="text"/> 5	<input type="text"/> 6
q) Dancing, e.g. ballroom, disco	<input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> 1	<input type="text"/> 2	<input type="text"/> 3	<input type="text"/> 4	<input type="text"/> 5	<input type="text"/> 6

11.

Number of times you did the activity in the past year

	Average time spent per episode:		Number of times you did the activity in the past year						
			Every day	3-6 times a week	Once or twice a week	1-3 times a month	Less than once a month	None ↓	
	hours	minutes							
r) Competitive running	<input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
s) Jogging	<input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
t) Bowling - indoor, lawn or 10 pin	<input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
u) Tennis or badminton	<input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
v) Squash	<input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
w) Table tennis	<input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
x) Golf	<input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
y) Football or hockey	<input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
z) Cricket	<input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
za) Rowing	<input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
zb) Netball, volleyball, basketball	<input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
zc) Fishing	<input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
zd) Horse-riding	<input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	

11.

**Average time
spent
per episode:**

hours minutes

Number of times you did the activity in the past year

**Every
day**

**3-6
times
a week**

**Once
or twice
a week**

**1-3
times
a month**

**Less
than
once
a month**

None
↓

ze) Snooker,
billiards,
darts

--	--	--

1

2

3

4

5

6

zf) Musical
instrument,
playing, singing

--	--	--

1

2

3

4

5

6

zg) Ice-skating

--	--	--

1

2

3

4

5

6

zh) Sailing,
wind-
surfing, boating

--	--	--

1

2

3

4

5

6

zi) Winter
sports
e.g. skiing

--	--	--

1

2

3

4

5

6

zj) Martial
arts

--	--	--

1

2

3

4

5

6

zk) Other
exercise
(please tick and describe)

--	--	--

1

2

3

4

5

6

.....

SECTION J: BUYING THINGS

J1. How difficult at the moment do you find it to afford these items:

		Very difficult	Fairly difficult	Slightly difficult	Not difficult	Don't pay for this
a)	food	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
b)	clothing	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
c)	heating	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
d)	rent or mortgage	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
e)	things you need for your children	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
f)	costs of educational courses (e.g. ballet, music, etc.)	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
g)	medical (including dental care and eye tests)	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
h)	child care	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
i)	a week's annual holiday away from home	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
j)	regular trips and out- ings for your child (e.g. with school, the family or someone else)	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
k)	something else (please tick and describe)	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>		

.....

J2. a) On average, about how much is the take-home family income each week (include social benefits etc.)?

less than £120	<input type="text" value="01"/>	£120 - £189	<input type="text" value="02"/>	£190 - £239	<input type="text" value="03"/>
£240 - £289	<input type="text" value="04"/>	£290 - £359	<input type="text" value="05"/>	£360 - £429	<input type="text" value="06"/>
£430 - £479	<input type="text" value="07"/>	£480 - £559	<input type="text" value="08"/>	£560 - £799	<input type="text" value="09"/>
£800 or more	<input type="text" value="10"/>	Don't know	<input type="text" value="11"/>		

b) Out of this, how much do you pay for rent, loans or mortgage each week?

nothing	<input type="text" value="1"/>	less than £40	<input type="text" value="2"/>	£40 - £59	<input type="text" value="3"/>	£60 - £79	<input type="text" value="4"/>
£80-£99	<input type="text" value="5"/>	£100- £119	<input type="text" value="6"/>	£120 or more	<input type="text" value="7"/>		
don't know	<input type="text" value="9"/>						

c) About how much do you spend on electricity, gas, water, and telephone each week?

less than £20	<input type="text" value="1"/>	£20 - £29	<input type="text" value="2"/>	£30 - £39	<input type="text" value="3"/>	£40 - £49	<input type="text" value="4"/>
£50 - £59	<input type="text" value="5"/>	£60-£79	<input type="text" value="6"/>	£80 or more	<input type="text" value="7"/>	don't know	<input type="text" value="9"/>

d) About how much do you spend on food for the whole family each week?

less than £20	<input type="text" value="1"/>	£20 - £29	<input type="text" value="2"/>	£30 - £39	<input type="text" value="3"/>	£40 - £49	<input type="text" value="4"/>
£50 - £59	<input type="text" value="5"/>	£60 - £79	<input type="text" value="6"/>	£80 - £99	<input type="text" value="7"/>		
£100 or more	<input type="text" value="8"/>	don't know	<input type="text" value="9"/>				

J2. e) About how much do you spend on clothing, hobbies, and entertainment each week?

less than £20	<input type="text" value="1"/>	£20 - £29	<input type="text" value="2"/>	£30 - £39	<input type="text" value="3"/>	£40 - £49	<input type="text" value="4"/>
£50 - £59	<input type="text" value="5"/>	£60 - £79	<input type="text" value="6"/>	£80 or more	<input type="text" value="7"/>		
don't know	<input type="text" value="9"/>						

f) About how much do you spend on childcare each week (e.g. after-school club, sitters, nursery)?

nothing	<input type="text" value="1"/>	less than £20	<input type="text" value="2"/>	£20 - £39	<input type="text" value="3"/>	£40 - £59	<input type="text" value="4"/>
£60 - £79	<input type="text" value="5"/>	£80 - £99	<input type="text" value="6"/>	£100 or more	<input type="text" value="7"/>		
varies	<input type="text" value="8"/>	don't know	<input type="text" value="9"/>				

g) Do you manage to save at all? Yes No

h) Is your household currently in arrears of rent, mortgage, electricity, gas, water, telephone or council tax?

Yes No

i) Has your family had to go into debt in the last 12 months to meet ordinary living expenses (e.g. rent, food, Xmas, or back-to-school expenses)?

Yes No

j) Do you receive any financial help from your parents, other relatives or friends?

Yes No

k) Do you help your parents, other relatives or friends financially?

Yes No

Food shopping:

J3. How often did you (or the shoppers in your household) buy the following items **in the last month** (4 weeks)?

	Most days ↓	2-3 times a week	Once a week	Once a fortnight	Once in the last 4 weeks	Not at all
a) Fresh fruit	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>	6 <input type="text"/>
b) Fresh vegetables	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>	6 <input type="text"/>
c) Meat	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>	6 <input type="text"/>
d) Meat pies or pasties	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>	6 <input type="text"/>
e) Fish	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>	6 <input type="text"/>
f) Cakes or biscuits	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>	6 <input type="text"/>
g) Sweets or chocolates	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>	6 <input type="text"/>

J4. a) Do you find the price of fresh fruit and vegetables:

cheap 1 reasonable 2 expensive 3

b) Would you (or the shoppers in your household) buy more fresh fruit and vegetables if they cost less?

Yes 1 No 2

J5. When you are choosing food for meals **for your family**, how much do the following influence your choice?

	A lot	Quite a bit	A little	Not at all
a) Cost	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>
b) What your children prefer to eat	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>
c) What you prefer to eat	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>
d) What other people prefer to eat (e.g. partner, other adult)	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>
e) Convenience of preparation	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>
f) What is good (healthy) for us to eat	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>
g) The special offers available when shopping	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>
h) Adverts/programmes on the television/radio	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>
i) Articles about food and recipes in newspapers/magazines	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>
j) Dietary requirements of a member of the family	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>
k) Other (please tick and describe)	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>

.....

J6. When you (or the shoppers in your household) do the food shopping do you:

	Never or rarely	Some of the time	Half of the time	Most of the time	Always
a) buy own brands/labels when available	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
b) buy special offers when available	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
c) buy large size packets or multibuy to get better value	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
d) check labels to see what is in the food or drink	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>

J7. Which one of these statements best describes the way you feel about your cooking?

I always enjoy cooking	1 <input type="text"/>
I enjoy cooking when I can take time over it	2 <input type="text"/>
I cook only because I have to, not because I enjoy it	3 <input type="text"/>
I avoid cooking if at all possible	4 <input type="text"/>
I have no real feeling towards cooking	5 <input type="text"/>

J8. Do you think about any of these health issues when choosing food?

	Yes often	Yes, sometimes	No, not at all
a) Heart disease	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>
b) Cancer	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>
c) Your weight	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>
d) Food allergies/intolerance	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>
e) Healthy teeth	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>
f) Other (please tick and describe)	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>

.....

J9. a) Do you drink tea? (If you only drink herbal tea, answer **No**)
 Yes 1 No 2 → **If no, go to J13 below**

If yes,

b) How often is the tea you drink decaffeinated?
 Always 1 Usually 2 Sometimes 3 Never 4

J10. We would like to ask how much tea, on average, you drink per day:

a) *If possible, please tell us first about the size of your cups and mugs. It would help us if you measured, in a measuring jug, the amount of liquid that your usual cup and/or mug contains. This will be in 'fl.oz' or 'mls'. If you can't measure them, don't worry, just tick the box to show which you use, and then go straight to J10b below.*

(i) I use a cup 1 → fl.oz **or** mls.

(ii) I use a mug 1 → fl.oz **or** mls.

b) How many cups of tea per day do you drink, on average? * cups a day

c) How many mugs of tea per day do you drink, on average? * mugs a day

* If you only drink the occasional cup and/or mug write 97

J11. How strong is the tea you normally drink?

Strong 1 Medium 2 Weak 3

J12. Describe the type of tea that you drink most often (e.g. Tesco Premium, Typhoo, Sainsbury's Red Label, Tetley Decaffeinated):

.....

J13. a) Do you drink coffee?

Yes 1 No 2 → **If no, go to Section K on page 60**

b) How often is the coffee you drink decaffeinated?

Always 1 Usually 2 Sometimes 3 Never 4

J14. a) If possible, measure the size of the cup and/or mug that you normally use for coffee, as described in J10 on page 58

(i) I use a cup

1

 →

--	--

 fl.oz **or**

--	--	--

 mls.

(ii) I use a mug

1

 →

--	--

 fl.oz **or**

--	--	--

 mls.

b) How many cups of coffee per day do you drink,

--	--

 cups a day
on average?*

c) How many mugs of coffee per day do you drink,

--	--

 mugs a day
on average?*

* If you only drink the occasional cup and/or mug write 97

J15. There are different sorts of coffee. Please say how many cups and/or mugs per day you usually drink of the following types:

	(i) cups	(ii) mugs				
a) Real coffee (e.g. Filter, cafetière, cappuccino)	<table><tr><td></td><td></td></tr></table>			<table><tr><td></td><td></td></tr></table>		
b) Instant coffee, less than <u>one</u> spoonful	<table><tr><td></td><td></td></tr></table>			<table><tr><td></td><td></td></tr></table>		
c) Instant coffee, one <u>level</u> spoonful	<table><tr><td></td><td></td></tr></table>			<table><tr><td></td><td></td></tr></table>		
d) Instant coffee, one <u>heaped</u> spoonful or more	<table><tr><td></td><td></td></tr></table>			<table><tr><td></td><td></td></tr></table>		
e) Other (e.g. office coffee machine) (Please tick and describe)	<table><tr><td></td><td></td></tr></table>			<table><tr><td></td><td></td></tr></table>		

.....

.....

J16. Describe the type of real coffee and/or instant coffee that you drink most often (e.g. Tesco Classic Gold, Nescafé Gold Blend, Kenco Decaffeinated, Lyons Original Cafetière):

a) Real coffee

b) Instant coffee

SECTION K:

K1. This questionnaire was completed by: (tick all that apply)

- a) Child's biological mother ☐
- b) Mother figure ☐
- c) Someone else ☐
(please tick and describe)

K2. Please give the date on which you completed this questionnaire:

day		month		year			
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
				2	0	0	

K3. Please give your date of birth:

day		month		year			
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
				1	9		

K4. Please give the date of birth of your study child:

day		month		year			
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
				1	9	9	

THANK YOU VERY MUCH FOR YOUR HELP

Space for any additional comment you would like to make

NB. Please remember we cannot reply to any comment unless you sign it.

When completed, please return the questionnaire to:

**Professor Jean Golding
Children of the Nineties - ALSPAC
Institute of Child Health
24 Tyndall Avenue
Bristol
BS8 1BR Tel: Bristol 928 8793**

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